

## INTRODUCTION

The *Status Report on Missouri's Alcohol and Drug Abuse Problems* is issued annually by the Missouri Department of Mental Health, Division of Alcohol and Drug Abuse. The primary purposes of this report are 1) to provide policy makers, planners, service providers, and researchers with a broad set of quantifiable measures and indicators of substance use, abuse, and addiction in Missouri, and 2) to provide comprehensive data describing the clients receiving services in treatment programs funded by the Missouri Division of Alcohol and Drug Abuse.

Criteria for identifying substance dependence and abuse are specified in the *Diagnostic and Statistical Manual of Mental Disorders, 4<sup>th</sup> Edition*. According to a recent national study, an estimated 7.3 percent of the U.S. population age 12 and older was dependent on or abused alcohol or illicit drugs in 2001 [65]; see “References” in the appendix. The study also found that 7.3 percent of the population age 18 and older had serious mental illness, and one-fifth of the mentally ill had a co-occurring substance abuse problem. Missouri's most recent needs assessment study estimated that 378,000 Missouri adults age 18 and older need alcohol or drug abuse treatment and 114,000 adolescents 12-17 years of age need intervention or treatment [47, 48]. Among the adults needing substance abuse treatment, approximately two-thirds described their own mental health as good, while one-third described it as fair or poor.

Substance abuse is treatable, yet private treatment is prohibitively expensive for the disproportionate number of people needing treatment who have low incomes and lack insurance coverage. In 1999, clients in 64 percent of substance abuse treatment admissions nationwide had no health insurance coverage for treatment. Medicaid provided coverage for an additional 14 percent. Only 22 percent of clients had private insurance or other forms of payment [62]. For those unable to afford services, publicly funded programs are necessary. The Missouri Division of Alcohol and Drug Abuse administers state and federal funding to provide the majority of publicly supported substance abuse treatment services in Missouri. A national treatment program survey conducted annually consistently indicates that these Division-funded programs provide services to approximately three-fourths of all Missouri residents who receive treatment [64, 69]. Therefore, of the 492,000 Missouri residents (378,000 adults and 114,000 adolescents) estimated to need treatment services in the Missouri prevalence study, a projected 369,000 are expected to require public support. In fiscal year 2002, the Division of Alcohol and Drug Abuse was able to provide treatment and clinical intervention services to 51,273—only about one-seventh of the estimated number who need publicly-supported services [25]. Based on a study by the Substance Abuse and Mental Health Services Administration, in a recent year in Missouri the treatment gap—the number of persons needing but not receiving treatment for illicit drug use—was estimated to be over 67,000 [63]. The study did not estimate the state's treatment gap for alcohol abuse and dependency services.

According to recent studies, the societal costs of substance abuse in the United States were \$184.6 billion for alcohol abuse in 1998 [57], \$160.7 billion for drug abuse in 2000 [71], and \$157 billion for cigarette smoking in 1999 [54]. These nationwide costs total \$502.3 billion per year, and Missouri's share of this burden is estimated to be \$10 billion. On a per capita basis, substance abuse has an annual cost of almost \$1,800 per Missouri resident, including more than

\$1,200 per resident for alcohol and drug abuse. These costs include loss of productivity due to substance abuse related illnesses and deaths, motor vehicle crashes, fire destruction, crime, fetal alcohol syndrome, acquired immune deficiency syndrome (AIDS), and the treatment and support of people with substance abuse problems.

Treatment for substance abuse has a good success rate and is cost effective. Missouri recently completed a follow-up study of clients receiving treatment in programs funded by the Division of Alcohol and Drug Abuse [46]. The study identified several positive treatment outcomes. Two-thirds of the clients were not using alcohol or drugs six months after entering treatment, and three-fourths of those not using at six months were also not using one year after entering treatment. Overall, about one-half of the clients in the study were abstinent at both the 6-month and 12-month follow-ups. Clients showed improvement in the areas of employment, physical and mental health, family and social relations, and legal status. The number of clients with illegal income diminished, and average monthly income more than doubled. Studies from other states and from corporations with employee assistance programs have documented substantial cost savings and other benefits from substance abuse treatment [61]. The California Treatment Assessment study conducted follow-up on about 3,000 clients [59]. The study documented large taxpayer savings due to reductions in crime. Treatment episodes lasted an average of about three months and cost \$1,400, but yielded average savings of about \$10,000 per client. In contrast to the huge annual societal per capita costs of substance abuse cited earlier, the federal Center for Substance Abuse Treatment has estimated that a full continuum of services for addictive disorders could be provided to everyone needing treatment for a per capita expenditure of only \$45 per year [60].

## **DATA CONTENT AND FORMAT**

The types of substance abuse measures and indicators presented in this report are commonly used by other federal and state authorities. Some data are direct measurements of substance abuse events such as consumption of alcohol and drugs during pregnancy, impaired driving crashes, and emergency room visits for drug overdoses. Others—such as unemployment, domestic violence, and exposure to certain communicable diseases—have a statistical correlation but are not always related to substance abuse. National and state estimates of alcohol and other drug use prevalence typically are derived from a combination of analyses including household interviews or telephone surveys and a variety of direct and correlate data. Alcohol and other drug abuse have a profound impact on a wide range of quality of life factors such as health, family relations, education, economic prosperity, housing, and legal status. As discussed below, a broad array of data is needed to quantify these impacts.

Health problems associated with substance abuse range from prenatal alcohol and drug exposure—causing newborn addiction or lifelong impairments—to chronic diseases resulting in several of the leading causes of death. Much of the prenatal exposure data is underreported. Alcohol and drug related deaths and hospitalizations are quantified based on the International Classification of Diseases (ICD) coding developed by the World Health Organization. Mortality data began being coded using ICD-10 in 1999, resulting in a change in the complex set of rules

for selecting the single underlying cause of death from among several interrelated causes. The reader is urged to use caution in comparing pre-1999 data on deaths with more recent data. Hospital and emergency department data continue to be based on the ICD-9 codes.

Public safety is compromised through alcohol and drug related traffic crashes, violence and non-traffic injuries resulting from intoxication, the dangerous environments of illicit drug manufacturing and distribution, and crimes committed to purchase addictive drugs. Victims of violence are more likely to be seriously injured if their perpetrators have consumed alcohol and/or other drugs [70]. Traffic crashes are categorized according to whether they resulted in fatalities, injuries, or property damage, and whether there was the presence of any of a set of standard conditions that are known to contribute to their occurrence. Alcohol and drug involvement are two of these quantifiable conditions noted in Missouri traffic crash reports. Beginning in 2001, new federal data submission requirements for the Uniform Crime Report (UCR) program have resulted in large increases in crime reports. Due to these changes, the 2001 data cannot be directly compared to the crime data from earlier years. Drug offenders and persistent DUI/DWI offenders continue to comprise a substantial portion of incarcerations and probation or parole openings.

Substance abuse also contributes to interpersonal conflict, family disintegration, domestic abuse, and emotional suffering. One-half of domestic violence perpetrators are believed to be addicted to alcohol or drugs, and an estimated 80 percent of child abuse cases involve parental substance abuse [60]. The inclusion of a variety of juvenile court referral data in this report underscores the strong connection between familial substance abuse and other family dysfunctions. Perhaps most striking is the number of children removed from their homes because of alcohol or drug abuse by their parents or caregivers.

Substance abuse is over-represented among people with low educational achievement, unemployment, and poverty. Public school dropout rates, unemployment rates and vocational rehabilitation admissions for alcohol and drug disabilities are productivity indices included in this report.

New federal and state laws and enforcement regulations have been enacted during the past several years to restrict youth access to tobacco. A separate section summarizes the current status of tobacco regulation, merchant education, and youth tobacco use in Missouri.

To illustrate trends, U.S. prevalence tables and Missouri data tables and charts include counts or rates from the most current year available and several past years. Indicator and treatment data are provided for each of the five Division of Alcohol and Drug Abuse administrative regions and 20 Service Areas. An illustration of these regions and service areas is included in the Appendix of this report. The data in these tables is provided for the most current year available and the two preceding years. Due to reconfigurations of Service Areas 8 and 12 on July 1, 2002 involving Morgan and Pettis counties, data for these Service Areas for prior years has been adjusted. Data is provided in the same format for Missouri's 115 counties, arranged according to Federal Information Processing Standards (FIPS) county code. Each data element reflects 12 months of activity and reflects a calendar year unless specified as "FY" for state fiscal year (July 1 - June 30) or "FFY" for federal fiscal year (October 1 - September 30).